



Patient Intake Form

First name _____ Middle Init. ____ Last Name _____

Female/Male. (Circle one) DOB _____ Age _____

Street Address _____

City/State _____ Zip Code _____

Mobile Phone (____) _____ Home Phone (____) _____

Email _____ Marital Status _____ Occupation _____

Emergency Contact _____ Phone (____) _____

Referred by _____

Please describe the main reason for your visit today:

Please indicate if you have any of the following conditions (check one):

- Pregnant
- HIV/Aids positive
- Hepatitis
- Tuberculosis
- Cardiac pacemaker
- Seizure disorder
- Bleeding disorder/on blood thinners
- Fainting disorder
- Other (please specify) _____

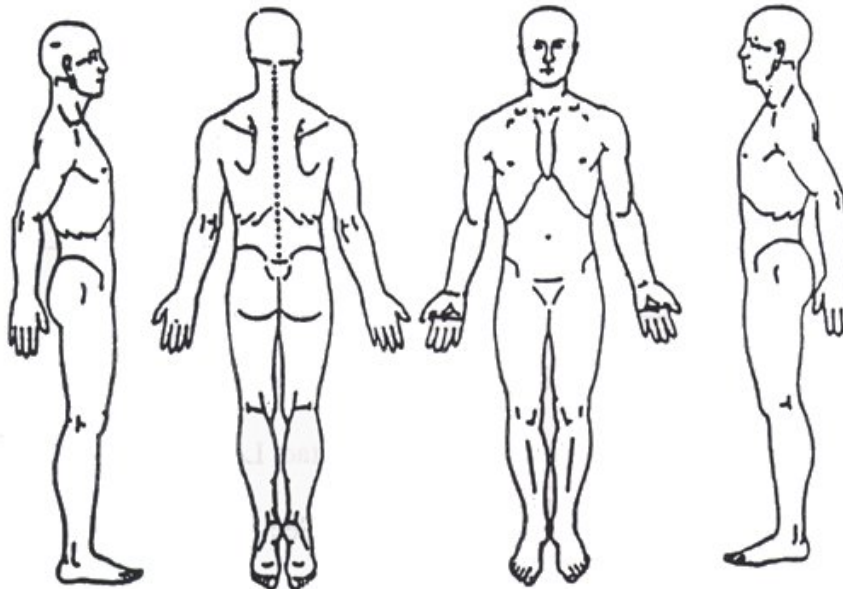
List all major childhood and adult illnesses, surgeries, major accidents and/or injuries:

List any medications, supplements (incl. herbs and vitamins) you're currently taking:

Please check off any of the following that you indulge in (type and amount per week):

- Exercise _____
- Sugar/dessert/artificial sweeteners _____
- Coffee/Tea _____
- Caffeinated products (e.g. energy drinks, soda, etc.) _____
- Alcohol _____
- Drugs (*no judgment here...please be honest*) _____
- Salty foods _____
- Water intake (indicate # of glasses per day) _____

Please indicate distressed areas with an "x" and rate your level of pain on a scale of 1 (minimal pain) to 10 (a lot of pain).



- Poor Circulation to limbs and/or hands and feet.
- Cold hands and feet
- Fatigue
- Heat sensation in hands and feet, chest or limbs
- Night sweats
- Catches colds easily
- Sweats easily during daytime
- Dizziness
- Seeing floaters, prisms of light or black spots

- Palpitations
- Sores on tongue
- Rashes or hives
- Restlessness
- Anxiety
- Chest pain
- Insomnia

- Cough
- Sinus congestion
- Dry ENT
- Allergies -Seasonal
- Allergies -Food related
- Chills/fever
- Sore throat
- Difficulty breathing

- Low appetite
- Loose stools
- Constipation
- Abdominal bloating
- Bruises easily
- General feeling of heaviness
- Mental fogginess
- Swollen hands/feet
- Bad breath
- Large appetite
- Prone to mouth canker and cold sores
- Painful, bleeding or swollen gums
- Heartburn
- Belching
- Stomach pain
- Nausea/vomiting

- Diarrhea alternating w/ constipation
- Skin Rashes
- Angers easily
- Migraines or Headaches
- Tremors
- Muscle spasms
- Low back pain
- Sore, cold or weak knees
- Frequent urination
- Incontinence (lack of bladder control)
- Hair Loss
- Memory problems
- Tinnitus (ear ringing)
- Libido is (circle one): Normal. Low. High

Please check all symptoms that pertain to you at this current time.

- Please indicate any other symptom you're having that isn't listed on this form:

Women Only

Are you pregnant now:

- Yes.
- No

Please answer even if you no longer have a menses.

Is/was your menses regular

- Yes.
- No.

Average number of days in flow: _____

The flow is:

- Normal.
- Light.
- Heavy.

The color is:

- Bright red.
- Dark Red.
- Purple.
- Brown.

Do/did you have any of the following menstrual related symptoms (circle all that apply):

- Blood clots
- Cramps
- Nausea
- Breast pain/tenderness
- PMS
- Break through bleeding between periods
- Heavy vaginal discharge between periods

Men Only

Do you have any discomfort or issues with your reproductive organs (circle all that apply)?

- Discharge
- Pain or swelling of the testicles
- Ejaculatory problems
- Impotence/Erectile Dysfunction

